

SSB 6569: Patient Out-of-Pocket Cost Task Force Report



Washington State Department
of Health

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Executive Summary

Many Washingtonians with chronic medical conditions report hardship in meeting the out-of-pocket (OOP) costs associated with prescription drugs needed for their treatment. When patients find it difficult to afford their out-of-pocket expenses for prescription drugs, many struggle with adherence or forgo treatment altogether, resulting in negative health impacts.

The Washington State Legislature directed the Department of Health (DOH) to convene a task force to discuss possible strategies and policy options to address this challenging issue.

The task force discussed the following benefit design strategies to reduce the impact of OOP costs on patients in the near term (2- 5 years):

- Strategy 1: Implement Standardized Benefit Design
- Strategy 2: Set Requirements around Medication Formularies/Drug Tiers
- Strategy 3: Directly Limit Patient Out-of-Pocket Costs

The task force also discussed improving transparency of coverage and cost to patients through pre- and post-purchasing decision-making tools. While decision-making tools do not reduce costs, they can help patients select the best cost and coverage option available to them.

Finally, while many task force members agreed that addressing long-term factors—such as the rising cost of prescription medications—was outside the scope of the task force, many felt state government should look for opportunities to address these underlying factors in the future.

Introduction

The Washington State Legislature passed SSB 6569, 'Creating a task force on patient out-of-pocket costs,' which directed the Department of Health (DOH) to convene a task force to explore the pressing issue of Patient Out-of-Pocket Costs (OOP Costs) in Washington State. Specifically, this task force identified causes and evaluated alternatives to address high OOP costs, particularly related to prescription medication, and weighed the potential impact on health outcomes.

The report includes many of the strategies and policy options discussed by the task force, initial assessments of positive and negative attributes for different options, and broad conclusions from the task force. We decided not to try to reach consensus decisions as a group, but rather vet ideas and produce a report in which conflicting positions and perspectives could coexist, painting a more comprehensive picture of this challenging issue.

Scope and Purpose of Task Force

Given the complexity of the topic, limited timeframe and budget, and the intention of the legislation, the department decided to focus the task force work on addressing OOP costs for prescription medications.

More specifically, the task force explored these three concerns:

- 1) Reducing OOP drug costs for patients with conditions that require extremely expensive drugs.
- 2) Reducing OOP drug costs for people who cannot afford to buy their medications.
- 3) Reducing the impact of large OOP drug costs in the first quarter of the year.

The task force ultimately chose to develop a menu of options for the legislature to consider that could address many of the impacts of OOP costs for prescription medications.

Problem Statement and Background

Premiums, deductibles, and cost-share expenses are all on the rise; however, deductible and coinsurance costs are rising much faster¹. Patients who must take multiple medications, or who take medications with particularly high cost sharing, have the greatest problems paying for them. This leads to negative impacts both for individuals and communities as patients are more likely to struggle with adherence. While this problem is largely rooted in increased OOP prescription drug costs outpacing incomes, it's important to note that patients cannot always choose alternatives to drugs prescribed for their conditions. Furthermore, in most cases, patients do not know how much their drugs will cost when developing a treatment plan with their providers or before selecting a health plan.

¹Payments for cost sharing increasing rapidly over time (Peterson-Kaiser Health System Tracker, April 2016)
<http://www.healthsystemtracker.org/insight/payments-for-cost-sharing-increasing-rapidly-over-time/>

This issue has national scope and is now being considered and addressed at both state and national levels. Several states have already begun the process of implementing laws, rules, and policies aimed at managing high out-of-pocket drug costs.

Factors Influencing OOP Drug Costs and Impacts of these Costs

At the first meeting, task force identified some of the factors contributing to OOP prescription drug costs as well as some impacts resulting from them.

Some of the factors that task force members mentioned included:

- **Lack of information**
 - Unknown costs of prescription drugs – patients are not always provided sufficient information to understand what the cost of their medications will be when choosing a health plan;
 - Coinsurance – most plans have patients pay a percentage of the prescription drug costs as coinsurance. When patients do not know how much their prescription drugs cost, it is very hard to understand what 30% coinsurance will mean for their OOP costs;
 - Lack of provider information – providers lack tools to identify patient costs when prescribing medications, leading to missed opportunities to consider similar drugs that may be more affordable;
 - Inherent health status uncertainty – health problems can be unexpected or unpredictable in their severity. Patients may have no way to foretell what health challenges and related treatments they will need in the coming year.
- **Increasing Costs of Healthcare and Medications** – Many members cited the increasing cost of healthcare and prescription drugs as a factor in increased OOP costs for patients. For low-income patient and patients with comparatively high prescription drug expenses, OOP prescription drug costs can be difficult to afford even with planning.

Task force members placed impacts into two broad categories:

- **Individual Health Impacts** – these impacts include decreased use of necessary care and disparate impact on health status;
- **Societal Impacts** – beyond individual impacts, high OOP costs also affect communities. These include both indirect costs to the state, such as decreased productivity, inability to send kids to college, or even family instability, as well as direct costs, such as increased Medicaid caseloads.

Menu of Strategies and Policy Options

The task force grouped options into three categories: benefit design, transparency, and underlying factors.

Category 1: Benefit Designs to Reduce the Impact of Out-of-Pocket Rx Drug Costs on Patients

- Implement standardized benefit design
- Set requirements around medication formularies/drug tiers
- Directly limit patient out-of-pocket costs

Category 2: Coverage and Cost Transparency

- Improve pre-purchasing transparency tools
- Improve post-purchasing transparency tools
- Standardize formulary definitions and limit changes to formularies

Category 3: Underlying Factors Influencing Patient Out-of-Pocket Costs

In presenting these options, the task force does not assert they are the only or best strategies; rather, they are the options most fully discussed in meetings. The strategies have been divided into three categories and include (a) description, (b) the positive and negative implications, and (c) conclusions.

Category 1: Benefit Design to Reduce the Impact of OOP Prescription Drug Costs on Patients

Benefit design strategies to reduce the impact of OOP prescription drug costs on patients share several core characteristics. They:

- Provide relief for patients in the relatively near future (2 – 5 years);
- Focus on individuals who have very high OOP prescription drug costs;
- Address the amount patients can be charged for prescription drugs.

The table below provides information on each of these strategies.

CATEGORY 1: BENEFIT DESIGNS TO REDUCE THE IMPACT OF OOP RX DRUG COSTS ON PATIENTS	
Strategy	Policy Options
Strategy 1: Implement standardized benefit design	Require all insurance plans to follow a standardized benefit design for all plans
	Require insurers to offer at least one plan meeting standard plan design for each metal tier

Strategy 2: Set requirements around medication formularies/drug tiers	Set requirements or conditions for placing prescription drugs in tiers
	Limit number of drug tiers or prohibit specialty tiers
Strategy 3: Directly limit patient out-of-pocket costs	Limit cost-sharing per prescription <ul style="list-style-type: none"> • Prohibit or limit coinsurance for medications • Fix or limit copayments for medications • Limit deductibles for medications
	Limit annual prescription drug maximum OOP costs (MOOP)
	Limit cost-sharing for specific conditions

Strategy 1: Implement Standardized Benefit Design

Several states have enacted laws requiring various levels of standardization in health insurance plan design, primarily directed at reducing the OOP obligations of policyholders. For example, California requires that all plans sold on the exchange adhere to a standardized model in each metal tier. Colorado mandates that 25% of the plans on each metal tier offered by the insurer adhere to the standardized benefit design. Montana requires that at least one plan in each metal tier adhere to the standardized benefit design.

Positive aspects:

- Easier for patients to compare plans and select the one that best fits their needs;
- Can be designed to limit OOP prescription drug costs or other covered benefits, increasing affordability;
- At least one standardized plan in each metal tier provides consumers with more choices;
- OOP prescription drugs costs could be more predictable;
- Could inspire innovation as insurers look to differentiate their plans.

Negative aspects:

- Standardizing all benefits in all plans across all metal tiers would restrict consumer choice and limit innovation;
- Could result in higher premiums, narrower networks, or other effects to offset shifting costs.

Task Force Summaries/Conclusions:

Task force members generally thought the best approach to standardized benefit design would be to require that an insurer offer a minimum of one standardized plan in each metal level. Task force members who supported this idea believe it will benefit patients with high OOP prescription drug costs by lowering prescription cost sharing, shifting cost sharing into premium, and making OOP prescription costs more predictable throughout the year.

Many task force members also supported obtaining more data on the impacts of this strategy. Seven states have implemented some form of standardized benefit design. Members suggested it would be helpful to obtain more data to determine the longer-term impacts this approach might have on OOP prescription drug costs and premiums.

Strategy 2: Set Requirements around Medication Formularies/Tiers

This strategy would increase regulation of a carrier's formulary—a list of prescription drugs offered by health plans, often organized by tiers. Many plans include multiple tiers for prescription drugs, and consumers incur costs based on the cost-sharing amount assigned to the tier by the carrier. These tiers have escalating copayments at each level with the specialty tier often requiring patients to pay a percentage-based coinsurance benefit instead of a flat copay. For example, patients using prescription drugs on these specialty tiers may have to pay 30% of the cost of the prescription drug.

There is significant variation in how different states have implemented this option. Some passed legislation limiting plans to just three formulary tiers (MA, VT, NY), some eliminated specialty tiers (NY), and another prohibited insurers from placing all or most drugs for the same condition on any specialty tier (DE).

Positive Impacts:

- Standardizing drug tier definitions and limiting tiers could streamline consumer shopping experiences, and allow more accurate comparisons between plans and carriers;
- Setting certain requirements around drug tiers could make some drugs more affordable, distribute cost sharing more equally across drug tiers and spread costs across a broader range of people;
- This approach puts limitations on drug cost sharing while not affecting the insurer's existing authority regarding other plan design elements.

Negative impacts:

- Reducing or capping costs for higher tiered drugs would likely increase cost sharing in lower tiers;
- Would likely increase pre-authorization requirements and increase premiums or deductibles;
- Eliminating specialty tier could possibly lead to use of coinsurance for non-specialty drugs;
- Could reduce the incentive for patients to use a lower cost medication that is equally effective and safe.

Strategy 3: Directly Limit Patient Out-of-Pocket Costs

Examples in this category include limiting annual OOP prescription drug costs to \$3500 per year (ME), limiting deductibles for medications in non-grandfathered individual and small group plans (CA), and requiring plans to use fixed copays ranging from \$20 to \$225 (MA).

Positive Impacts:

- Would lower OOP prescription drug costs for patients with the highest OOP prescription drug costs;
- Provides greater predictability;
- Mitigates large first quarter expenses.

Negative Impacts:

- Could simply shift costs to other areas for consumers;
- Could result in more restrictive prescription drug management requirements;
- May not be feasible for bronze level plans due to actuarial value regulatory requirements;
- Could narrow provider networks.

Task Force Summaries/Conclusions:

The task force generally felt that while these strategies could lower OOP prescription drug costs for those who incur the greatest expenses, insurers would likely shift costs to premiums or other benefits.

Category 2: Coverage and Cost Transparency

Unlike the strategies above in Category 1, the Coverage and Cost Transparency strategies do not propose structural changes or directly reduce costs. Instead, they improve transparency and help patients select the best cost and coverage options available to them.

Among these strategies, members felt that pre-purchasing transparency tools are more important than post-purchasing transparency tools, although most task force members agreed both could be useful.

CATEGORY 2: COVERAGE AND COST TRANSPARENCY	
Strategies	Policy Options
Strategy 4: Improve pre-purchasing transparency tools	Require insurers to use a standard formulary template for their plans
	Require insurer to have searchable formularies

	Require insurers to provide tools like the Medicare Part D tool that would allow patients to assess costs pre-purchase
Strategy 5: Improve post-purchasing transparency tools	Require insurers to improve cost estimator tools so the actual cost-sharing amount for a given medication under a particular plan is available to patients and providers in real time
Strategy 6: Standardize formulary definitions and limit changes to formularies	Standardize definitions of all drug tiers
	Standardize definition of specialty tier
	Prohibit changes to tiers within a plan year

Strategy 4: Improve Pre-Purchasing Transparency Tools

Several members felt the pre-purchase tools were more important than post-purchase tools because it allowed consumers to see potential coverage and costs before being locked into an insurance plan for a year.

Members discussed a range of options that might achieve this goal, including requiring a standard formulary template and tools such as the cost estimator for Medicare Part D, where consumers can enter the medications they use and can receive real-time estimates of their costs.

Strategy 5: Improve Post-Purchasing Transparency Tools

Post-purchase tools, such as a cost calculator, can also be helpful for consumers. One prescriber shared that such a tool would allow her to work with her patient in real time to make the best choice for them when selecting a course of treatment.

Strategy 6: Standardize formulary definitions and limit changes to formularies

A final section of strategies to improve coverage and cost transparency included policy options such as standardizing definitions for formulary tiers, standardizing definitions for specialty drugs, and prohibiting the change of tiers within a plan year. Most task force members agreed that these policy options would be challenging to accomplish and were not a priority of the task force members.

Task Force Summaries/Conclusions:

Most task force members felt that cost transparency was an important issue to continue to work on. In terms of cost transparency tools, most task force members agreed that while pre-purchase transparency tools would have more impact, both would be helpful.

Category 3: Underlying Factors Influencing Patient Out-of-Pocket Costs

Throughout our meetings some members expressed the concern that many of the strategies and options put forward would not directly address underlying problems that drive high OOP prescription drug costs.

Most members concluded that these other factors fell outside the scope of the task force as the state is preempted by federal law in regulating the price of prescription drugs. However, other members felt that the state should consider opportunities to address these underlying factors, such as increasing transparency around the pharmacy supply chain, reducing the price of medications by consolidating purchasing power at the state level, and advocating for changes in federal policies.

Conclusions

High patient OOP prescription drug costs has a profound impact on many Washingtonians, particularly those with chronic and complex health conditions.

Through three in-person meetings, and work occurring between those meetings, the following strategies that have been discussed in this report for the legislature's consideration:

Category 1: Benefit Design to Reduce the Impact of Out-of-Pocket Prescription Drug Costs

- Strategy 1: Implement standardized benefit design
- Strategy 2: Set requirements around medication formularies/drug tiers
- Strategy 3: Directly limit patient out-of-pocket costs

Category 2: Coverage and Cost Transparency

- Strategy 4: Improve pre-purchasing transparency tools
- Strategy 5: Improve post-purchasing transparency tools
- Strategy 6: Standardize formulary definitions and limit changes to formularies

Category 3: Underlying Factors Influencing Patient Out-of-Pocket Costs

Patient OOP prescription drug costs remain a significant issue in Washington, and work with this task force confirms it will be a challenging issue to resolve. We hope the material presented here, the discussions that informed it, and the relationships formed through the task force will help move the state forward toward finding new solutions to improve the health of all Washingtonians.

DOH would like to thank all task force members for generously donating time and resources needed to complete this project. While everyone contributed, we particularly would like to thank the following task force members who gave presentations that helped inform our work:

- Dr. Bill Dowling, UW School of Public Health
- Sarah Kwiatkowski, Office of the Insurance Commissioner
- Kirsten Axelsen, Pfizer
- Julie Cooper, Premera

Appendix A: Taskforce Member List

Taskforce Member	Organizational Affiliation
Darren Cline	Seattle Genetic Inc.
Patrick Connor	National Federation of Independent Business/Washington
Sheri Nelson	Association of Washington Business
Michelle Fox	Yakima Valley Farm Workers Clinic
Ryan Pistoresi	Washington State Health Care Authority
Molly Voris	Washington Health Benefit Exchange
Sarah Kwiatkowski	Washington State Office of the Insurance Commissioner
Jason McGill	Governor's Office
Thea Mounts	Washington State Office of Financial Management
Ian Corbridge	Washington State Hospital Association
Lesa Ellis	Providence Health and Services
Dekker Dirksen	Community Health Plan of Washington
Julie Cooper	Premera Blue Cross
Kathleen Beery	Group Health Cooperative
Zach Snyder	Cambia Health Solutions
Susie Dade	Washington Health Alliance
William Dowling	UW School of Public Health
Erin Dziedzic	Dziedzic Public Affairs
Johanna Lindsay	Formerly of the Arthritis Foundation
D. Mark Baker	Lifelong
Mary McHale	American Cancer Society Cancer Action Network, Inc.
Stephanie Simpson	Bleeding Disorder Foundation of Washington
Eugene May	National Multiple Sclerosis Society, Greater NW Chapter
Dave Mastin	JDM Consulting, LLC.
Kristen Axelsen	Pfizer Inc.
Kelli Strother	Otsuka America Pharmaceuticals
Julie Akers	WSU College of Pharmacy
John Jones	Pharmaceutical Care Management Association
Katie Kolan	Washington State Medical Association
Veena Shankaran	UW School of Medicine; Fred Hutchinson Cancer Research Center
Teresa Mosqueda	Washington State Labor Council, AFL-CIO
Sybill Hyppolite	SEIU 1199NW
Daniel Gross	Northwest Health Law Advocates

Appendix B: Task Force Meeting Summary

OVERVIEW OF TASK FORCE MEETINGS	
Introductory Webinar (6/30/2016)	We launched the task force with a one-hour webinar, providing members with information on task force composition, and background on project scope and goals. We also outlined our approach going forward with the three in-person meetings.
In-Person Meeting 1 (8/3/2016)	<p>The task force discussed factors leading to high patient out-of-pocket costs and its impacts on patients. Task force member Dr. Bill Dowling, Professor Emeritus at the University of Washington, provided an overview, followed by time for task force members to share their own reactions and experiences with many of the trends Dr. Dowling highlighted. The group then discussed possible policy solutions.</p> <p>Members inquired about what efforts and strategies have been considered in other states. A subcommittee volunteered to research and report this information at the next meeting.</p>
In-Person Meeting 2 (9/9/2016)	<p>An overview of strategies other states have considered or implemented was provided by Sarah Kwiatkowski (OIC), Julie Cooper (Premera), and Kirsten Axelsen (Pfizer). Following each presentation, task force members discussed their reactions to the information, asked clarifying questions, and shared additional opinions, information, and ideas.</p> <p>DOH staff developed a policy framework document outlining the different policy options and strategies. Members then commented on the framework, and shared positive and negative aspects of each option. Members later completed a survey to prioritize topics for Meeting 3.</p>
In-Person Meeting 3 (10/10/2016)	The task force refined the policy framework and conducted in-depth discussions on the merits and limitations of different policy options. It also considered how to best present a menu of options to the legislature.

Appendix C: Policy option summary

CATEGORY 1: BENEFIT DESIGNS TO REDUCE THE IMPACT OF OOP RX DRUG COSTS ON PATIENTS	
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	Limit annual prescription drug maximum OOP costs (MOOP)
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CATEGORY 2: COVERAGE AND COST TRANSPARENCY	
Strategies	Policy Options
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Strategy 6: Standardize formulary definitions and limit changes to formularies	Standardize definitions of all drug tiers
	Standardize definition of specialty tier
	Prohibit changes to tiers within a plan year
CATEGORY 3: UNDERLYING FACTORS INFLUENCING PATIENT OUT OF POCKET COSTS	